INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST response to HMICFRS Policing inspection programme and framework commencing April 2022

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question.

2. Our response to this consultation is informed by our work on deaths in police custody or following police contact. INQUEST considers that cases resulting in death provide critical insight on policing and necessary learning on how to safely care for vulnerable detainees.

Do the proposed thematic inspections cover the areas that are of most concern to you at the moment? Which do you believe are of greatest importance or urgency?

3. INQUEST welcomes HMICFRS plans to complete three thematic inspections into issues of race and policing. We believe the proposed thematic inspections into race and policing, ethnic disproportionality in the criminal justice system and police leadership and culture (which aims to examine 'long-term questions about race and diversity') are much needed and long overdue.

4. It is our view these thematic inspections be treated as a priority in HMICFRS's inspection framework. For 40 years, INQUEST has documented a pattern of cases synonymous with state violence, neglect, structural racism, impunity and injustice. We have seen how a disproportionate number of Black people, in particular Black men, have died as a result of use of force by police officers. Analysis of INQUEST casework shows the proportion of BAME deaths in custody where restraint is a feature is over two times greater than it is in other deaths in custody. Further, the proportion of BAME deaths in custody where use of force is a feature is over two times greater than it is in other deaths in custody. In addition, the proportion of BAME deaths in custody where mental health-related issues are a feature is nearly two times greater than it is in other deaths in custody.[1]

5. The 2017 Angiolini Review[2] documented many of these issues but our casework indicates that not enough progress has been made by individual police forces to tackle the issue of disproportionality, warranting further oversight from HMICFRS.

6. We also welcome HMICFRS plans for continued scrutiny of policing issues relating to violence against women and girls and look forward to the completed inspection on the vetting of police officers and measures to prevent police corruption following the sentencing of Sarah Everard's murderer.

---

[1] For more information, see INQUEST statistics on BAME deaths in police custody https://www.inquest.org.uk/bame-deaths-in-police-custody

[2] Dame Elish Angiolini, Deaths and Serious Incidents in Police Custody, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf, January 2017

Are there any significant new or emerging problems in policing that HMICFRS should consider when it inspects individual police forces?

7. INQUEST has the following concerns relating to emerging problems in policing arising out of our recent casework on deaths of individuals in police custody or following police contact:

    a. **Mental health.** The police's response to individuals in a mental health crisis continues to be a central issue of concern in our cases and in the past year INQUEST has seen an increase in cases of deaths following police contact. In particular we have concerns regarding: a lack of understanding of the risks associated with mental ill health and the need in some cases for emergency medical intervention; poor information gathering and sharing on an individual's level of risk; inadequate use of the Mental Health Tactical Advice Service (MHTAS); failures to conduct basic checks such as whether an individual has previously presented as a suicide risk and to enquire about the existence of self-harm and suicide markers on the police systems; and inconsistent use of police powers under section 136 of the Mental Health Act. Notably, we raised similar issues in our response to HMI Prisons and HMICFRS's 2016 consultation on inspection expectations.[3] We believe these issues should be examined as a priority in the course of HMICFRS's 2022 inspection framework.
    b. **Road Traffic Accidents (RTAs).** INQUEST has seen an increase in deaths involving police RTAs. Specifically, our casework has highlighted troubling instances of the following: deaths involving officers driving at speed; officers driving with no lights or sirens; and officers dangerously driving over pedestrian crossings. In one INQUEST case, a police officer was ultimately convicted for running over and killing a 23-year-old man and subsequently received a two year suspended sentence. These cases raise important questions over the effectiveness of police training and the appropriateness of police policy on the discretionary use of sirens during a vehicular pursuit. According to official statistics from the Independent Office of Police Conduct, in 2020/21 there were 25 fatalities from 20 police-related road traffic incidents (RTIs) which is an increase of one death in 2019/20.[4]
    c. **Use of civilians.** Finally, we have worked on cases where civilians have been allowed to participate in police restraint operations and an individual has subsequently died. We are concerned by the fatal use of force by security guards in some of these cases where the police were present and where welfare checks were also not carried out. We believe the decision-making associated with the use of civilians to restrain individuals requires further oversight.

How else could HMICFRS adapt the way in which it acquires information to take account of current circumstances and risks to public safety?

8. INQUEST believe HMICFRS must do more to take account of important findings and recommendations arising from coroner's inquests. Properly conducted inquests can uncover harmful practices which can, in turn, facilitate learning and positive change for police forces

[3] INQUEST Response to HM Inspectorate of Prisons (HMIP) and HM Inspectorate of Constabulary (HMIC) Consultation, https://inquest.eu.rit.org.uk/Handlers/Download.ashx?IDMF=4f7269d6-30a8-41a1-93c0-b2b56867debf, 2016

[4] IOPC, https://www.policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-202021#:~:text=There%20were%2019%20deaths%20in,figure%20for%20the%20last%20decade, July 2021

to help prevent deaths. Coroners frequently issue Prevention of Future Death (PFD) reports which outline clearly the steps needed to prevent deaths and social harm.

9. However, there is currently no system in place to monitor the implementation of these recommendations and the rich information on policing practices arising from inquests remains underused by inspection bodies. INQUEST's long-standing campaign is for the Government to establish a National Oversight Mechanism which would have a duty to collate, analyse and monitor recommendations following inquests and inquiries and their implementation by public authorities.

10. In the absence of a NOM, we believe HMICFRS's inspection framework must be routinely informed by information brought to light in inquests concerning police-related deaths. Inspectors should monitor the conclusions and PFDs issued by coroners and keep track of emerging trends or repeated recommendations to help determine which areas of policing require further independent scrutiny.

11. In order to carry out its function to independently assesses the effectiveness and efficiency of police forces and fire & rescue services in the UK, we believe HMICFRS should regularly review the outcomes and recommendations from reports and investigations carried out by other independent bodies such as the Independent Office for Police Complaints. INQUEST also believes the Inspectorate could do more to take account of learning from cases of near-deaths.

Other comments

12. We have significant concerns over HMICFRS plans to adopt a 'blended approach' to inspections. INQUEST is of the view that inspections must, as the default, take place in-person rather than remotely. This is of crucial importance when inspecting police custody suites and seeking feedback from detainees. We believe in-person, unannounced inspections are indispensable in accurately assessing the treatment of and conditions for detainees.